Headquarters U.S. Air Force

Integrity - Service - Excellence

Procedures – When to Use

March 2004 Regional Coding
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Why do we use procedure codes?

- Decision making
  - Staffing (indicate workload)
  - Funding (e.g., new equipment)
  - Usually have relative value units – TMA budgeting
  - Potentially billable
  - Credentials
    - At other hospitals
    - Readiness Skills Verification Program (Air Force)

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Objective

- Identify categories of procedure codes based on AMA's Current Procedural Terminology (CPT) 2004
- Identify procedures with use restrictions in the Military Health System (MHS)
- Identify modifiers and quantity issues
- Identify discountable procedures
- Identify common procedures
- Identify common incorrectly coded procedures

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Overview

How to use the CPT 2004

- Index
- Section Guidelines
- No longer starred procedures * - thank goodness
- Add-on codes +
- Unlisted procedures

ADM Patient Encounter

ANT,ADAM 20/806-51-0101 AGE:51y

Appt Date/Time : 28 Jun 2003@1600 Type: ROUT Status: KEPT

Clinic: GENERAL SURGERY SAME DAY SURGERY MEPRS : BBA5

In/Outpatient: Outpatient APV: Yes Work Related: No

Appt Provider: BUNNY,EASTER Injury Date :

2nd Provider #1: CLAUS,SANTA Role: ASSISTING

2nd Provider #2: Role:

Disposition: RELEASED W/ WORK DUTY LIMITATIONS

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ICD-9 Dx Description Priority

+ 401.0 MALIGNANT HYPERTENSION 3

305.1 TOBACCO USE DISORDER U

250.60 DIABETES W NEULOL MANIF UNSPEC 4

278.01 MORBID OBESITY 2

Chief Complaint: 540.9 ACUTE APPENDICITIS NOS

ADM Patient Encounter - E&M Code Enter/Edit

ANT,ADAM 20/806-51-0101 AGE:51y

Appt Date/Time : 28 Jun 2003@1600 Type: ROUT Status: KEPT

Clinic: GENERAL SURGERY SAME DAY SURGERY MEPRS : BBA5

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ICD-9 Dx Description Priority

540.9 ACUTE APPENDICITIS NOS 1

278.01 MORBID OBESITY 2

401.0 MALIGNANT HYPERTENSION 3

250.60 DIABETES W NEULOL MANIF UNSPEC 4

========== Dx Lvl ==========

E&M Code Description (Maximum of 3 codes) 1-4 Mod1 Mod2 Mod3 Units

---

99499 UNLISTED EVALUATION AND MANAGEMENT SERVICE 1 1

Edit Icd-9 e&M Cpt/hcpcs Admin Code File View mail cUo eXit

ADM Patient Encounter - CPT/HCPCS Code Enter/Edit

ANT,ADAM 20/806-51-0101 AGE:51y

Appt Date/Time : 28 Jun 2003@1600 Type: ROUT Status: KEPT

Clinic: GENERAL SURGERY SAME DAY SURGERY MEPRS : BBA5

==========

ICD-9 Dx Description Priority

540.9 ACUTE APPENDICITIS NOS 1

278.01 MORBID OBESITY 2

401.0 MALIGNANT HYPERTENSION 3

250.60 DIABETES W NEULOL MANIF UNSPEC 4

========== Dx Lvl ==========

CPT/HCPCS Description 1-4 Mod1 Mod2 Mod3 Units

44970 LAPAROSCOPY, APPENDECTOMY 1 1

Do not code anesthesia on this encounter - Wrong MEPRS

00840 Anes for intraperitoneal lower abdomen 1 AA 1

J2250 INJ MIDAZOLAM HYDROCHLORIDE 1 20

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How to use the book

- Read and be guided by what is in the book
  - this is the basic guidance, the MHS **ADM Coding Guidelines are a supplement**
- Index
  - Organized by main terms with up to three modifiers
  - Classes of entries are
    - Procedure or service (ablation)
    - Organ or other anatomic site (abdomen)
    - Condition (abscess)
  - Synonyms, eponyms and abbreviations (Addam Operation – see Dupuytren's contracture)

How to use the book – categories of procedure codes

- Codes are 5 numbers
- 0xxxx Anesthesia
- 1xxxx-6xxxx Surgery (major focus today)
- 7xxxx Diagnostic Imaging
- 8xxxx Lab
- 9xxxx Medicine
- 992xx-99499 Evaluation and Management

How to use the book

- Read guidelines found before the section begins
  - Anesthesia (found before code 00100)
  - Surgery (found before code 10021)
  - Radiology (found before code 70010)
  - Pathology and Laboratory (found before code 80048)
  - Medicine (found before code 90281)

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Notes found within the sections

- Within the sections, e.g.,
  - Repair (Closure) – before 12001
  - Free skin grafts – before 1500
  - Destruction – before 17000
  - Musculoskeletal System – before 20100
  - Spine (Vertebral Column) – before 22100
  - Fracture and/or Dislocation – before 22305
  - Application of Casts and Strapping – before 29000
  - Psychiatry – before 90801
  - Psychiatric Therapeutic Procedures – before 90804
  - Ophthalmology – before 92002
  - Allergy and Clinical Immunology – before 95004

  - This is not anywhere close to a complete list. Depending on the CPT book you use, there will be other notes elsewhere. Your book may not have these.

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What symbols mean

Indented procedure example:

20550 Injection; tendon sheath, ligament, ganglion cyst

20551 tendon origin/insertion

20552 single or multiple trigger point(s), one or two muscle group(s)

20553 single or multiple trigger point(s), three or more muscle groups

20550 had been a starred procedure (if part of a larger procedure, do not code). Starred procedures went away. But, just like other procedures, you need to figure out if it is a integral part of a larger service (then only code the larger procedure done) or if it is a separate procedure (then code it).

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Add On Codes +

- Codes that are commonly carried out in addition to the primary procedure performed. See appendix E.
- When you see “each additional” or “List separately in addition to primary procedure.”
- Must never be reported as a stand-alone code
- Do not use modifier –51 Multiple procedures

11200 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

+11201 each additional ten lesions (List separately in addition to code for primary procedure)

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Unlisted codes

- For use when you do a procedure that is not listed in CPT or HCPCS.
- Usually end in a “99” (not always)
- Listed in the guidance for the section (e.g., Surgery Guidelines)
- In civilian sector need to submit a report to the insurer listing procedure and your charges
- In MHS these codes are set to zero RVUs
- If you can’t find a code for a specific procedure in CPT, look for one in HCPCS. For example: prolotherapy, cannot use 20552 per CMS guidelines. The correct code for prolotherapy is a HCPCS code.

Procedures - Medical Necessity

- A service that is reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member
  - consistent w/symptoms or dx of the illness or injury under treatment
  - consistent w/generally accepted professional medical standards
  - not furnished primarily for the convenience of the patient, the attending physician, or another physician or supplier; and
  - furnished at the most appropriate level, which can be provided safely and effectively to the pt

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Procedures - General

- Office visit codes should not be billed the same day as a procedure is performed unless
  - it is the first evaluation for that issue/done day identified
  - a completely separate problem
  - a change in plan

- Otherwise, when there is no applicable Evaluation and Management (E&M) code - use “holding” office visit code of 99499 for the day of the visit

Procedures – General

DOD idiosyncrasies

- Global “package” (99024)
- Surgical package (topical anesthesia)
- Obstetrics coding

Global procedures

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- Provides time frames that apply to each surgical procedure.
- 000=Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.
- 010=Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.
- 090=Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount.
-
- MMM=Maternity codes; usual global period does not apply.
- XXX=The global concept does not apply to the code.
- YYY=The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing.
- ZZZ=The code is related to another service and is always included in the global period of the other service.
- http://cms.hhs.gov/providers/putdownload/default.asp#pfsrelative
  - **National Physician Fee Schedule Relative Value File**
    RVU04_B.ZIP 1.3MB zip file -- Requires UNZIP software -- April 2004 revision file -- The revision includes the changes identified in CR3128, R105CP (adobe pdf 263Kb).

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Surgical Package

- see Surgery Guidelines
- include:
  - local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;
  - subsequent to the decision for surgery, one related E&M encounter on the date immediately prior to or on the date of the procedure (including the history and physical);
  - immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
  - writing orders;
  - evaluating the patient in the postanesthesia recovery area;
  - typical postoperative follow-up care.

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Obstetrics Coding

- Do not use the global obstetrics codes at this time unless you are Nellis AFB (alpha test site)
- 59400 Routine package with antepartum, delivery, post partum
- 59410 Vaginal w/postpartum
- 59425 4-6 visits global
- 59426 7 or more visits global
- 59510 Routine cesarean package
- 59515 Cesarean w/postpartum
- 59610 Routine vaginal after cesarean package
- 59614 Vaginal after c-section w/postpartum

Procedures – Discountable Surgical Procedures

Multiple procedure column of RVU table

http://cms.hhs.gov/providers/pufdownload/default.asp#pfsrelative

0=No payment adjustment rules for multiple procedures apply.

1=If procedure is reported on the same day as another procedure that has an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 25%, 25%, 25%, and by report).

2=If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report).

3=Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family

9=Concept does not apply.

Procedures - Surgical

Multiple procedures - Code the most expensive first, then code others.

-51 modifier for multiple procedures

CPT	Mod	Nomenclature	Work RVU
45378		Diagnostic colonoscopy	3.69
45378	53	Diagnostic colonoscopy	0.96
45379		Colonoscopy w/fb removal	4.68
45380		Colonoscopy and biopsy	4.43
45381		Colonoscopy, submucous inj	4.19
45382		Colonoscopy/control bleeding	5.68
45383		Lesion removal colonoscopy	5.86
45384		Lesion remove colonoscopy	4.69
45385		Lesion removal colonoscopy	5.30
45386		Colonoscopy dilate stricture	4.57
45387		Colonoscopy w/stent	5.90

http://www.hcfa.gov/medlearn/faqclaim.htm

- **Q.13. Would it be appropriate for a hospital to append a modifier '-25' to a CPT medical visit code, in order to be paid for a medical visit that is rendered in one clinic when, on the same day, in another hospital department, the same patient had an "S" or "T" indicator procedure performed? This appears to be the only way that a hospital would generate payment for both the medical visit and the procedure/surgical service.**
- **A.13. The hospital must report the visit code with a modifier '-25' and the procedure code. (07/07/00)**

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Procedures - General

- For follow-up visits, if the dx no longer exists (e.g., laceration, neoplasm, cyst) code only V-code for the follow-up visit or suture removal/dressing change

- Pain Management - is an office visit
  - But nerve blocks done during pain management visits are codable

Procedures - Anesthesia - Conscious Sedation

- Can only be used by surgeon doing procedures
- Includes monitoring of cardiorespiratory function (e.g., pulse ox, cardiorespiratory monitor, and BP)
- Must have independent trained observer to assist provider in monitoring patient
- 99141 Sedation, w or w/o analgesia; IV, IM, inhalation
- 99142 Sedation, w or w/o analgesia; oral, rectal and /or intranasal

Procedures - Surgical

- For repairs, code debridement only if requires prolonged cleaning or appreciable amounts of tissue removed
- Wounds are simple, intermediate or complex - add lengths of the same type and location to determine code
- Suture removal/dressing change under anesthesia other than local - 15850/1/2
  - don’t use 15850/1/2- instead use ICD-9-CM V58.3
  - S0630 - Removal of sutures by a physician other than the physician who originally closed the wound

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Procedures - Surgical

- Colonoscopy
- Drain abscess
- Drain blood from under nail
- Infant circumcision
- Remove cerumen
- Remove foreign bodies (ear, nose, eye, esophagus…)
- Remove nail
- Remove warts
- Strapping/splinting
- Treatment of fracture (the casting material is HCPCS code)
- Removal of cast is put on by someone other than in your MTF

Procedures - Lab/Rad/Diagnostic Imaging 7xxxx(DI) 8xxxx(Lab)

- Code if done and interpreted in the clinic e.g., most labs and diagnostic imaging not coded
  - Common exceptions, KOH for annual GYN, Diagnostic Ultrasound of Pelvis 76805-76857 in OB clinic
- But, need to document they were ordered on SF 600 so Third Party Collection knows to look for them

Procedures - Medicine

90000-99199

- If using code from this section without an E&M, use the 99499 “holding” code (this “work around” will go away when ADM is changed to accept procedures without an E&M)
- Immunizations
- Psychiatry (make sure time is annotated)
- Ophthalmology/Optometry
- EKG/treadmill…
- Allergy (each skin test is a unit)
- PT/OT (make sure time is annotated)
- Osteopathic manipulations/acupuncture/chiropractic
- Audiology

Procedures - Medicine
90000-99199

- Immunizations - consider coding when you tell the patient to stop by immunizations
- Injections - 90782/90784/90788 (make sure you have a J-code for the injectable)
- Psych Drug Mngt - 90862 - (ADHD) only use if no E&M, if in conjunction with E&M then it becomes part of the history/exam/decision
- Vision Screening – 99172/3

Procedures - Medicine

- **EKGs – 93010/Treadmills 93015**
  - If read by physician who orders – entered by that physician (if inpt, put in “A” MEPRS; if outpt, put in “B” MEPRS)
  - If ordered by one service, read by internist at administering facility – entered by internist in “D” MEPRS account
  - If read by internist at separate reading facility – entered in “F” MEPRS account
  - Only one person may take credit for tracing, only one may take credit for the reading/interpretation
- **Spirometry 94010**
- **Nebulizer 94640**
- **After hours services 99050/2/4/6/8**

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Procedures – Medicine Be careful

- 36400/36410/36415 Venipunctures – only use if this is only thing done, usually part of the visit
- 92002/4 Ophthalmologic services is NOT vision screening (99172/3)
- 92283 Color Vision exam, extended (e.g., anomaloscope)
  - pseudiosochromatic plates - such as Ishihara) not reported separately
- 93740 Temperature Gradient (not temp)
- 93784-93790 Blood Pressure - 24 hour - (this is not the B/P when a pt walks in)
- 97116 Gait Training (not crutches education)
- 98940-3 Chiropractic manipulation (not DO)

Procedures - Medicine

- Supplies and materials over and above
  - 99070
- Educational materials - if the military health system incurs a cost (not drug rep stuff) 99071
- Physician group education svs 99078
  - Use E&M of 99499
- Throat culture – no code for this

Procedures – Usually incorrect if used in the clinic (Jan 2003 list)

15850 –Removal of sutures under anest

15851 –Removal of sutures under anest

15852 –Dressing change not for burn

29xxx -Application of cast - probably should be tx of fx code if initial tx

29799 –Casting/strapping procedures - need more specific

36000 -PLACE NEEDLE IN VEIN

36410 -DRAWING BLOOD

36415 -DRAWING BLOOD

57410 -Pelvic exam under anesthesia (not colpo)

59400 -OB CARE global package

59425 -ANTEPARTUM CARE package

59426 -ANTEPARTUM CARE package

7xxxx- X-rays

76825 – Echo exam of fetal heart

76827 – Echo exam of fetal heart

8xxxx - Labs done in lab

90862 – Med mngt

90885 – Psych eval of records

92283 – Color vision exam

93307 – Echo exam of heart

93770 – Measure venous pressure

93784 – Ambulatory BP monitoring

93786 – Ambulatory BP monitoring

97116 – Gait training therapy

97535 – Self care mngt training

Procedures – Usually incorrect if used in the clinic (Nov 2003 list)

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Code	Description, done in AFMS in Nov 03	Fac Tot RVU	AFMS #
99071	Patient education materials	0	4621
99078	Group health education	0	2302
90862	Medication management	1.3	1575
36415	Routine venipuncture	0	819
99000	Specimen handling	0	692
97116	Gait training therapy	0.67	526
87081	Culture screen only	0	350
H0033	Oral med adm direct observe	0	241
87070	Culture, bacteria, other	0	202
92283	Color vision examination	1.05	186
36540	Collect blood venous device	0	183
87110	Chlamydia culture	0	110
93770	Measure venous pressure	0.26	97
76827	Echo exam of fetal heart	2.63	95
88142	Cytopath, c/v, thin layer	0	95
93307	Echo exam of heart	5.34	94
A4615	Cannula nasal	0	94
88150	Cytopath, c/v, manual	0	94
59899	Maternity care procedure	0	94
15850	Removal of sutures	1.12	70
29799	Casting/strapping procedure	0	58
71020	Chest x-ray	0.95	52
71010	Chest x-ray	0.74	46
90845	Psychoanalysis	2.4	45
76000	Fluoroscope examination	1.59	45
88147	Cytopath, c/v, automated	0	45
15852	Dressing change,not for burn	1.29	
A4580	Cast supplies (plaster)	0	24
87158	Culture typing, added method	0	22
87650	Strep a, dna, dir probe	0	22
D4920	Unscheduled dressing change	0	18
78466	Heart image (3d), multiple	14.3	17
78461	Heart muscle blood, multiple	6.64	17
84999	Clinical chemistry test	0	16
77417	Radiology port film(s)	0.62	14
86631	Chlamydia antibody	0	14
15851	Removal of sutures	1.25	13
87077	Culture aerobic identify	0	13
73630	X-ray exam of foot	0.79	12

Procedures – Usually incorrect if used in the clinic (Nov 2003 list)

73630	X-ray exam of foot	0.79	12
73610	X-ray exam of ankle	0.79	12
74000	X-ray exam of abdomen	0.79	12
P3000	Screen pap by tech w md su	0	12
88199	Cytopathology procedure	0	11
73140	X-ray exam of finger(s)	0.62	10
87491	Chylmd trach, dna, amp prob	0	10
73110	X-ray exam of wrist	0.79	9
85025	Complete cbc w/auto diff wbc	0	9

Procedures – Usually incorrect if used in the clinic (Nov 2003 list)

CPT	Descr, in AFMS APV Nov 03	RVU
44640	Repair bowel-skin fistula	31.93
44140	Partial removal of colon	32
50840	Replace ureter by bowel	32.18
50948	Laparo new ureter/bladder	33.18
44202	Lap resect s/intestine singl	33.34
22554	Neck spine fusion	34.76
63075	Neck spine disk surgery	35.67
43860	Revise stomach-bowel fusion	37.33
44626	Repair bowel opening	37.98
43846	Gastric bypass for obesity	39.24
22224	Revision of lumbar spine	40.44
59400	Obstetrical care	43.29
58210	Extensive hysterectomy	45.72
22548	Neck spine fusion	47.02
58240	Removal of pelvis contents	60.63

Why? Do you need a new code?

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- **If you are coding this more than 5 times per year, and you would like a HCPCS code for it, please let me know. It may justify a new code.**

17999 (Skin tissue procedure)
19499 (Breast surgery procedure)
29799 (Casting/strapping procedure)
41899 (Dental surgery procedure)
59899 (Maternity care procedure)
85999 (Hematology procedure)
90749 (Vaccine toxoid)
90882 (Environmental manipulation)
90899 (Psychiatric service/therapy)
92499 (Eye service or procedure)
94799 (Pulmonary service/procedure)
97799 (Physical medicine procedure)
99000 (Specimen handling)
99070 (Special supplies)
99071 (Patient education materials)
99090 (Computer data analysis)
99091 (Collect/review data from pt)
99199 (Special service/proc/report)

Modifiers

- Why
- Not all can be used in all situations
- Common modifiers
- When to use each

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Modifiers - Why

- To explain that there was something unusual about the procedure
- Used with CPT codes and HCPCS codes
  - In Appendix A of Current Procedural Terminology (CPT)
  - Level I – CPT, code in the “Mod 1” after the procedure in ADM
  - Physical Status Modifiers – for anesthesia code 0xxxx

Common Modifiers

- -26 Professional Component:
  - When a procedure has a tech and professional component and you are only coding the provider's portion. Usually not used as the technician and provider are both in the same clinic and it is a waste of time for both to code (the provider takes the entire code).
  - Examples:
    - 59025 Fetal non-stress test
    - 51795 Voiding pressure studies; bladder

Common Modifiers

- -50 Bilateral Procedure: Some codes naturally bilateral such as tonsillectomy. Some are not, such as tumor removals and treatment of fractures.
  - Example: Under Breast Excision – all codes for bilateral procedures have been deleted. To report, add modifier “-50”
  - Excision of breast cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion, open, male or female, one or more lesions (from both breasts), code 19120-50

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Common Modifiers

- -51 Multiple Procedures
  - Procedures done at the same time which are not
    - E&M
    - Add-on procedures (see appendix E)
    - Exempt from “-51” (see appendix F), you can tell these in the book as there is a
  - For example:
  - 45334 Sigmoidoscopy, flexible; with control of bleeding
  - 45332-51 with removal of foreign body

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Modifiers

- 22 UNUSUAL PROCEDURE SERVICES
- 26 PROFESSIONAL COMPONENT
- 32 MANDATED SERVICES
- 50 BILATERAL PROCEDURE
- 51 MULTIPLE PROCEDURES
- 52 REDUCED SERVICES
- 53 DISCONTINUED PROCEDURE
- 55 POST-OP CARE ONLY
- 56 PRE-OP CARE ONLY
- 58 STAGED/RELATED PROCEDURE/SVC BY SAME PHYS POST-OP
- 59 DISTINCT PROCEDURAL SERVICE

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Modifiers

- 76 REPEAT PROCEDURE BY SAME PHYSCIAN
- 77 REPEAT PROCEDURE BY ANOTHER PHYSCIAN
- 78 RTN TO OR FOR RELATED PROC DURING POST-OP PERIOD
- 79 UNRELATED PROC/SVC BY SAME PHYS DURING POST-OP PER
- 90 REFERENCE (OUTSIDE) LAB
- 99 MULTIPLE MODIFIERS
- CC PROCEDURE CODE CHANGED - INCORRECT CODE FILED
- E1 UPPER LEFT, EYELID
- E2 LOWER LEFT, EYELID
- E3 UPPER RIGHT, EYELID
- E4 LOWER RIGHT, EYELID

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Modifiers

- F1 LEFT HAND, SECOND DIGIT
- F2 LEFT HAND, THIRD DIGIT
- F3 LEFT HAND, FOURTH DIGIT
- F4 LEFT HAND, FIFTH DIGIT
- F5 RIGHT HAND, THUMB
- F6 RIGHT HAND, SECOND DIGIT
- F7 RIGHT HAND, THIRD DIGIT
- F8 RIGHT HAND, FOURTH DIGIT
- F9 RIGHT HAND, FIFTH DIGIT
- FA LEFT HAND, THUMB

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Modifiers

- LC LT CIRCUMFLEX CORONARY ARTERY
- LD LEFT ANT DESC CORONARY ARTERY
- **LT LEFT**
- RC RT CORONARY ARTERY
- **RT RIGHT**
- **TC Technical component**

Modifiers

- T1 LEFT FOOT, SECOND DIGIT
- T2 LEFT FOOT, THIRD DIGIT
- T3 LEFT FOOT, FOURTH DIGIT
- T4 LEFT FOOT, FIFTH DIGIT
- T5 RIGHT FOOT, GREAT TOE
- T6 RIGHT FOOT, SECOND DIGIT
- T7 RIGHT FOOT, THIRD DIGIT
- T8 RIGHT FOOT, FOURTH DIGIT
- T9 RIGHT FOOT, FIFTH DIGIT
- TA LEFT FOOT, GREAT TOE

Quantity

- Kind of confusing
  - Some things just considered bilateral but not stated in book (e.g., 42825, tonsillectomy)
  - Some things “one or both” (e.g., 69210, removal impacted cerumen, one or both ears)
  - Some things unilateral (e.g., 30300, removal foreign body, intranasal; office type procedure)

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Common Quantity Codes

- Unit of time procedures, e.g.,
  - 96100 Psych testing, per hour
  - 97802 Medical nutritional therapy, ea 15 min
- “Each additional” procedures, e.g,
  - 11101 Biopsy of skin, subQ tissue and/or mucous membrane, each separate/additional
  - 90472 Immunization admin, each additional
  - 90781 IV infusion therapy, each additional hour (requires provider presence)
  - 95004 Allergy testing, percutaneous, specify number of tests

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RVUs and CMAC

- Most CPT codes have an associated RVU and CMAC
- “Unlisted” codes do not have RVU (and therefore no CMAC) as until you write a small report about the procedure, we do not know what you did
- Other codes without RVU/CMAC usually because procedure has no “average” time/resources
  - Group education – could be one hour or eight hours
  - Special transportation – could be taking patient from clinic to inpatient mental health facility; could be taking inpatient from mental health facility back to her home base 1,000 miles away

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Future Talks

- March – CPT Procedures
- April – HCPCS
- May – ICD-9-CM
- June – Business of Coding (CPT and HCPCS)
- July – Aggregate Audits
- August – Documentation
- September – Super Bills
- October – Using Clinical Data (ICD-9-CM)

- Talks subject to change

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Questions?

- E-mail your service POC:
  - Lazo, Cielito V. GS BUMED [CVLazo@US.MED.NAVY.MIL]
  - Zoblosky Shirley M Civ AFMOA/SGZZ [Shirley.Zoblosky@brooks.af.mil]
  - Garza Alicia C Civ AFMOA/SGZZ [Alicia.Garza@brooks.af.mil]
  - Army – e-mail PASBA coding help desk
- Or e-mail jeanne.yoder@pentagon.af.mil

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Anesthesia Modifiers

- AA – done by anesthesiologist
- AD – medical supervision (more than 4 cases at the same time)
- G8 – Monitored anesthesia care – deep complex, complicated, or markedly invasive
- G9 – MAC for pt w/hx of severe cardio-pulmonary condition
- GK – Medical direction 2, 3 or 4 cases at the same time)
- QS – MAC
- QY – Medical direction of one CRNA by anesthesiologist
- QZ – CRNA service w/o physician medical direction

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Ambulatory Payment Classification

- A – Svs paid under a different method (e.g., PT)
- C – Inpt svs not paid under Outpatient Payment System (OPPS) (don't expect to see as APVs, inpt consults)
- E – Payment not allowed under OPPS. Medicare may not use code or may not be covered. Look at the 9938x/9939x, t-cons, inpt and home care.
- F – Corneal tissue acquisition costs paid separately
- G – Drug or biological paid as pass-through
- H – Device paid as pass-through
- K – Non-pass-through drug/biological
- N – Incidental, packaged into another service or APC (observation)
- P – Paid only in partial hospitalization
- S – Paid under OPPS, multiple procedure reduction does NOT apply
- T – Paid under OPPS, multiple procedure reduction applies (skin things)
- V – Medical visits (99201-99215, ER,outpt consults) allowed under hosp OPPS
- X – Ancillary svs allowed under hospital OPPS